Dental Care PLUS

The plus is service.

100 Crowne Point Place • Cincinnati, OH 45241
Phone (513) 554-1100 • 1-800-367-9466

ALL SECTIONS MUST BE COMPLETED FOR APPLICATION TO BE PROCESSED.

ENROLLMENT FORM

SOCIAL SECURITY NUMBER ___ ___	GROUP NUMBER	EMPLOYER AND LOCATION	
EMPLOYEE LAST NAME / FIRST NAME / MI		EMPLOYEE'S HOME PHONE	EMPLOYEE'S WORK PHONE
HOME ADDRESS / APT.#		SEX	DATE OF BIRTH
CITY / STATE / ZIP CODE		COUNTY IN WHICH YOU RESIDE	
MARITAL STATUS ☐ SINGLE (01) ☐ MARRIED (02) ☐ SEPARATED (05) ☐ WIDOWED (03) ☐ DIVORCED (04)	EMPLOYMENT DATE	EFFECTIVE DATE	

APPLICATION FOR DENTAL COVERAGE (CHECK ONE)

☐ SINGLE (EMPLOYEE ONLY) ☐ FAMILY (EMPLOYEE PLUS DEPENDENTS) ☐ DOUBLE (EMPLOYEE PLUS ONE DEPENDENT WHEN APPLICABLE)

COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE COVERED BY THE PLAN

	NAME – IF LAST NAME DIFFERENT FROM ABOVE INDICATE LAST NAME	RELATIONSHIP	SEX	BIRTH DATE
01		SPOUSE		
02				
03				
04				
05				
06				
07				

A. Will you or any dependent be covered under another dental insurance plan while a member of Dental Care Plus Insurance Company?

Yes _____ No _____

If yes, name and address of other insurance company _____ Policy # _____

B. Does spouse carry any type of dental care coverage? _____ Yes _____ No Spouse's birthdate _____

Name of spouse's dental insurance _____

Address _____ Phone _____

Effective date of spouse's coverage _____ Policy # _____

Single Plan _____ Family Plan _____ Spouse's social security number _____

REFUSAL/WAIVER – COMPLETE ONLY IF YOU ARE DECLINING COVERAGE FOR YOURSELF OR ANY DEPENDENT

I DECLINE COVERAGE FOR ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN

REASON FOR REFUSAL _____

Any person obligated for any part of a premium rate in connection with an enrollment agreement, may cancel such agreement within seventy-two (72) hours after having signed an offer to enroll. Cancellation occurs when written notice of the cancellation is given to Dental Care Plus Insurance Company or its agents/representatives. A notice of cancellation mailed to Dental Care Plus is considered to have been filed on its postmark date.

On behalf of myself and any dependants listed above, I hereby apply for coverage under the Master Group Contract issued to my employer by Dental Care Plus Insurance Company. I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any changes provided for therein. I understand that certain services may require copayment, coinsurance or deductible, payable by me (or my dependents) directly to the provider of such services.

I authorize my employer to deduct the necessary contributions, if any, from my wages or salary, with the understanding that he acts as my agent in all dealings with the plan, and that all acts performed by him and all notices given to him in such dealings are binding upon me, as not prohibited by statute or regulation.

I hereby waive the dentist-patient privilege and authorize any dentist or other provider of dental services to give Dental Care Plus Insurance Company, its agents and representatives any information concerning the claims for reimbursement for covered services of any person included under such coverage, including the undersigned, the undersigned's spouse and the undersigned's dependents.

I certify that, to the best of my knowledge, the above information is complete, true, and correct.

X EMPLOYEE SIGNATURE _____ **DATE** _____

CITY/STATE _____

Notice: The state of Ohio requires that we provide you with the following information: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.